Newbold Surgery

New Patient Questionnaire
15 YEARS AND UNDER

Please take time to complete the following questionnaire.
This will enable us to assess any treatment you may need in the near future.
Any other medical history will be transferred from your medical records when we receive them from your previous GP.

Please complete ALL questions

Full Name:	Today's Date:	
Address:	Sex:	
	Ethnic Origin: (Please circle) White British White Other Chinese Asian Indian Asian Pakistani Asian Chinese Asian Bangladeshi Asian Other Black Caribbean Black Other Black African Mixed – White/Black African Mixed – White/Asian Mixed - Other Mixed – White/Black Caribbean Other Ethnic Background ……	
Post Code:		
*Home Tel:		
*Mobile Tel:		
I consent for communications to be sent via text message or email. Signed:		
I **DO NOT** consent for communications to be sent via text message or email. Signed:		
Email address:		
Next of Kin: Relationship: Address: Tel No:	Date of Birth:	
	*NHS Number:	
***It is extremely important that we have up to date telephone numbers in case we have to contact you urgently.**	*Your NHS No. **MUST** be completed, without it we can not process your application. (You can obtain this number from your previous GP)	
Do you have any learning disabilities?	Yes	No
Do you have a carer?	Yes	No
Are you a carer?	Yes	No
If you answered yes to either of the carer questions, please ask at reception for a carers pack.		
Do you suffer from any allergies?		
Are you sensitive to any medication?		
Are you the child of a member or previous member of the Armed Forces?		

You will need to be seen in our chronic disease clinics if you take regular medication for any of the illnesses listed below.

Illness/Condition	Please indicate if you suffer from these illnesses and will need to attend the relevant clinics in the near future.
Asthma	
Diabetes	
Epilepsy	
Mental Health	
Rheumatology	
Substance Misuse	
Any other known illness	

We routinely offer all new patients a New Patient Health Check. These are less suitable for children but if for some reason you would like your child to attend, please telephone the surgery 2 weeks after registration to make an appointment. The New Patient Health Check will be offered within the next 6 months.

Summary Care Record

Please indicate if you consent to sharing a summary of your Medication, Sensitivities, Allergies and Adverse Reactions to other Health Care Professionals in an emergency situation. Examples may include contact with GP out of Hours service, Emergency visits to A&E and being seen as a Temporary Resident by a GP whilst on holiday etc. A leaflet regarding Summary Care Records is available on request.

I **consent** to my Medication, Sensitivities, Allergies and Adverse Reactions to be included in the Summary Care Record.	I **do not** wish to be included in the Summary Care Record but understand that I can change my mind regarding this at any time.
Signed:	Signed:
	If you have decided to opt out of the Summary Care Record you **must** complete an Opt-out form. These are available from Reception.

You may want to include other important information on your Summary Care Record which you think would be helpful in an Emergency situation. Please speak to a member of staff for further details. Additional information will only be shared with your express consent.

Thank you for taking time to complete this questionnaire.
Please return it to reception where your registration will be processed.